7 tips for presenting refractive cataract surgery to patients

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Cataract surgery has more options than ever, but counseling patients on out-of-pocket refractive options for cataract surgery without feeling like a salesman can be tricky. In “7 tips for presenting refractive cataract surgery to patients,” Richard Tipperman, MD, and Shamik Bafna, MD, offer pearls for counseling patients on options to help them make the best decision for their refractive goals. These tips—including choosing the right wording and bringing in patients’ family members—could help improve your conversion rate, as they did in Dr. Bafna’s practice.

As health care becomes more complex, the desire for high quality but less expensive care has increased. At the University of Southern California, a Virtual Care Clinic (VCC) is aiming to change the way health care is pursued. The VCC will allow patients with smartphones to interact with doctors and obtain reliable patient education information. “On your mobile device, you can contact the physician, and an avatar of that physician will interact with you, wherever they are, and answer questions one on one,” said Rohit Varma, MD. In addition, patients can use the physician avatar to obtain information they may have forgotten, such as drug precautions or how to instill eye drops. Read more about this innovative new program in “Virtual Care Clinic transforms traditional health care model.”

Physicians are faced with a myriad of insurance options, and while they may be familiar with the ones that allow them to practice and run a business, there are other policies worth considering as well—such as cyber liability coverage. The types of policies and coverage can be overwhelming, so be sure to read “Are you sure you’re covered?” This article presents some lesser know insurance offerings and resources to learn more about the different options.

This issue also contains useful information on conducting local surveys to capitalize on potential LASIK patients in “How potential patient research improves your LASIK marketing”; looking at long-term indicators to get a clear backdrop of what is going on in the markets in “Long-term indicators can provide buy or sell signals”; and adding dry eye services to your practice in “The ‘opportunity’ in dry eye is the chance to improve patient outcomes.” If there is a topic you would like to see covered in a future issue, please contact us.

As we close the year, the staff of Ophthalmology Business would like to wish you and your family a happy and healthy holiday season. We look forward to providing more practical articles to help you in 2017.
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Physicians at the University of Southern California (USC) in Los Angeles are taking a digital lead in the future treatment of patients with the Virtual Care Clinic—and the university's ophthalmology department will help lead the way.

The Virtual Care Clinic (VCC), will allow patients with smartphones to interact with doctors and obtain reliable patient education information.

The system is undergoing some testing now, and it will begin to formally roll out the end of this year or the beginning of next year, said Rohit Varma, MD, MPH, interim dean, Keck School of Medicine of USC, professor and chair, Department of Ophthalmology, and director, USC Roski Eye Institute. The VCC will begin at the USC Eye Institute and the USC Institute of Urology, but it will eventually involve all specialties at the university.

**What it is and how it works**

The VCC was created in collaboration with the USC's Center for Body Computing and Institute of Creative Technology, along with several foundational partners.

The VCC will have several functions, including the ability to treat patients remotely. The way it works is fairly straightforward, Dr. Varma said. “On your mobile device, you can contact the physician, and an avatar of that physician will interact with you, wherever they are, and answer questions one on one,” he said.

In a specialty like ophthalmology, the reliance on visual images to evaluate a patient makes digital diagnosing easier, Dr. Varma said. However, the VCC’s functions go further. Patients can use the VCC to access health information with the help from their physician avatar. For this part, the actual physician is not involved, just the avatar. This breaks the traditional model of a patient either relying on sketchy information online or asking their doctor questions during a visit, when they feel their provider may be rushed, said Leslie Saxon, MD, cardiologist and professor of clinical medicine, Keck School of Medicine of USC, and founder and executive director of the USC Center for Body Computing. In fact, some of the research behind the VCC has found that patients are more likely to disclose information and ask questions of an avatar versus real humans. “If the person could dial up their doctor on their own time and learn about a procedure or illness when they are not emotional, and perhaps recruit the digital help...
Virtual Care Clinic transforms traditional health care model

Dr. Varma said.

once you create an avatar, it becomes very easy for the physician to sit wherever they are and provide interaction and information through the avatar,” Dr. Varma said.

Why ophthalmology?

Of all specialties available, why is the VCC rolling out first in ophthalmology? Aside from Dr. Varma’s personal enthusiasm for the project, there’s a logical reason that any ophthalmologist would understand.

“It was a matter of which specialty was more technologically interested and savvy. We in ophthalmology love devices and all kinds of gadgets. We’re more technologically inclined, and the next generation of treatments is going to come in the interface between digital aspects, engineering, and medicine,” Dr. Varma said. The university’s background in these areas—for example, with the development of the Argus II retinal implant (often called the bionic eye) and an on-demand pump to provide medication to patients with age-related macular degeneration or diabetic macular edema—also make ophthalmology’s leading role a natural fit.

The big picture

It’s no secret that there’s a huge investment in digital health right now, and the VCC is part of that, Dr. Saxon said. Yet there are several other motivations behind the VCC.

As more institutions from developed countries build campuses in developing parts of the world, the VCC would like to reach more patients digitally versus via bricks and mortar, Dr. Varma said. There are definite hopes and plans to reach patients in remote areas of the U.S. and around the globe with the concept.

As health care becomes more complex, the desire for high quality but less expensive care has increased, Dr. Saxon said. Much in the way that mobile technology has transformed the media and music industries (and many other businesses), concepts like the VCC can change the way that health care is pursued, Dr. Saxon thinks. As every health institution aims to cut costs further, a digital system should help physicians to concentrate on where their work is needed most, she added.

The power of digital already has changed the preferences of many people of the younger generations who prefer a digital interaction, Dr. Saxon said—and she’s surprised by the number of elderly patients who feel better taken care of with a digital connection. “They tend to feel taken care of even though they don’t see me. They almost attribute too much to the remote care, even beyond what’s there,” she said.

The exposure that patients will have to reliable health information also can help improve health literacy, Dr. Saxon said.

The connection between patient sensors and the VCC has a role in preventing disease, Dr. Varma thinks. With USC’s location in the movie industry town of Los Angeles, Dr. Varma likens the role of the VCC to the movie “The Minority Report” with Tom Cruise. There is a pre-crime division in the movie that aims to anticipate crime before it occurs. “This is going to be more of a pre-disease anticipatory unit where if we’re beginning to see things not going right in the individual based on sensor data, we can intervene early,” he explained. “If we have sensors telling us things are going wrong in the eye, we can prevent people from losing vision and going blind. That’s a huge accomplishment.”

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How potential patient research improves your LASIK marketing

by William B. Rabourn Jr.

Part two: Benefits of local market surveys

Part one of this series, “Benefits of multi-market surveys,” introduced the dangers of stagnant LASIK marketing tactics in a changing market. It discussed the outdated trends from the early 2000s that still permeate practices’ LASIK marketing messages and strategies. These trends include:

• Messages touting the efficiency and effectiveness of modern LASIK technology
• The assumption that the target LASIK audience is between 25 and 54 years of age
• The assumption that average myopia patients are around 40 years of age, while hyperopia patients are estimated to be about 50
• The assumption that patients turn first to friends and family for LASIK information

These messages and assumptions fail to acknowledge the change in economic conditions and the increased use of information technology to connect with health care professionals more conveniently. Many practices have lost touch with the wants and needs of their potential patients. Today’s patients have different concerns, interests, characteristics, and resources than those in the late 1990s and early 2000s.

Part one used the demographic and socioeconomic data collected from Medical Consulting Group’s 2015 eight-market LASIK online survey (funded by CareCredit) to illustrate how multi-market surveys can be used to familiarize a practice with its market(s) and to optimize its LASIK message (read part one in the September 2016 issue of Ophthalmology Business). Part two uses the same data to provide a second option for marketers who are more interested in generating leads by zeroing in on one specific market.
Summary of MCG’s eight-market LASIK survey background

Eight custom quantitative LASIK survey markets were completed. The call-to-action offered participants the chance to win a prepaid gift card to stimulate survey responses. These unaided, unbranded surveys were posted both on a highly visited site and throughout the actively engaged Facebook community in each market as follows:

- Atlanta
- Austin, Texas
- Dallas
- Denver
- Los Angeles
- Minneapolis
- New York
- Orlando, Florida

For consistency, each market received the same survey distributed through similar channels using the same call-to-action. The data was extracted from 1,300 total surveys. Survey questions were multiple choice for ease of use.

The benefits of local market surveys

A local market survey is beneficial for everyone but especially those not interested in expanding their market and instead concerned with capitalizing on their local potential patients.

It is important to remember that while relying on multi-market surveys performed by others can be highly useful in helping to note consistencies and trends in patient demographics and desires across the field, they are still big pictured-oriented. Multi-market survey results that do not include a marketer’s local market do not guarantee that the
wants and needs of a marketer’s local potential LASIK patients align with that of the majority. By narrowing in the scope of research, LASIK marketers can pick up some of the unique characteristics of their market. It is also often the more economic option for those who are not interested in expanding to other markets but who are still looking for greater message customization.

MCG’s study offers numerous examples of this customization potential. Here are two:

1. While in all markets the “51 or above” age range was most prominent, individual markets showed a new, younger age group (20 to 30, 31 to 40 age group. Understanding the age groups in their market helps marketers determine what kind of conversation to have with potential patients in their advertising and where to initiate that conversation (Figures 1, 2, and 3).

2. While the combined market survey results for household income show that about 50% of each market falls into the “$25,000 or less” range, closer inspection shows that markets like Denver and Dallas actually have a slightly higher percentage of potential patients who fall into the $50,000 to 74,999 income range and therefore may be more easily able to afford LASIK—another factor that will affect LASIK messaging (Figures 4 and 5).

Defining your goal and formulating strategies
Practices that look at their LASIK service through the lens of the potential patient and use that perspective to shape their messaging may be more likely to generate leads. The issue has always been getting inside the patient’s mind.

Start by defining your goals. A local market survey is ideal for understanding the unique demographics, socioeconomic traits, needs, and
When physicians get sick

by Liz Hillman, Staff Writer

Overcoming denial and stigma to do what’s right for your health

Extensively trained to recognize and treat illnesses and ailments in others, some admit doctors, while good at taking care of their patients, might not be so at taking care of themselves.

Robert Klitzman, MD, professor of psychiatry, director of the Masters of Bioethics program, Columbia University, New York, and author of the book When Doctors Become Patients, said there are a number of problems that can arise with medical professionals and their own health care behaviors.

“A lot of doctors say they feel like they wear a magic white coat: Disease is out there and not with me,” he said. “They’re trained to look at disease in someone else, but not in themselves.”

“One doctor said as he was driving home, he felt some pain in his shoulder and in his back. He went home and pulled out his old med school textbook and read a heart attack could present that way. So he got in his car and drove himself back to the hospital,” Dr. Klitzman said.

There are dozens of studies and surveys looking at how physicians and residents take care of themselves—or don’t—from all over the world. These look at everything from psychological issues to stressors to burnout to diet and exercise to more extreme sickness.

Simply by participating in regular market research, practices can determine to which marketing strategies and messages their potential patients are more receptive. A relevant message is more likely to generate a significant return on a practice’s LASIK marketing investment.

Mr. Rabourn is founder and managing principal of Medical Consulting Group in Springfield, Missouri. He can be contacted at bill@medcgroup.com.

A survey of nearly 800 doctors in Barcelona found that of those who responded, 49% admitted to not having a primary care physician themselves, and 47% did not attend preventative health visits provided by their employer.¹ The survey found that more than half (52%) said they asked personal health advice from their colleagues, but less than half (48%) followed that advice. Eighty-two percent said they wrote their own prescriptions.

A more recent survey of 337 internal medicine residents in the U.S. found that half had a primary care physician but nearly 80% did not have an annual physical.² Two out of three surveyed said they missed doctors’ appointments due to their training schedules. And yet, 70% said they felt their performance in

continued from page 10

continues on page 12
residency was “suboptimal because of [a] health condition and also felt sick but did not drop the call.” Half of those in the survey were concerned about a possible psychiatric illness, but only about 17% had received an evaluation.

Another survey of nearly 500 residents at an academic medical center—90% of whom responded—published in 2015 found that while 89% were aware of a policy that allotted them time off to take care of their health, only 49.7% used it. “The most commonly reported barrier to policy use was concern about the impact the resident’s absence would have on colleagues.”

### Denial

Dr. Klitzman said that many doctors, when presented with possible illness in themselves, minimize or deny their symptoms and continue to work.

“A lot of doctors have been schooled to be workaholics. … You get a lot of praise for being a workaholic,” he said. “One doctor [in my book] said, ‘When I got sick, I thought if I continued to work and took care of more patients, then I would be a super doc, and I wouldn’t die.’ Other doctors, even doctors with metastatic cancer, have continued to work. It’s hard for them to take care of themselves because they get so much praise for working.”

There are also “taboo” topics that doctors and those in non-medical professions alike have trouble talking about.

“A few of these doctors said, ‘I became depressed and it took 6 months for me to tell my doctor, I’m depressed and need treatment.’ The same with sexual side effects. A few of these doctors said they had sexual side effects due to various medications, but ‘it took six visits and 6 months for me to say to my doctor … can we address that?’ These are difficult topics to talk about for anyone, and it’s hard for these doctors to talk about these issues, too.”

### Stigma

What will my colleagues think? What will my patients think? Diagnosis of an illness can raise these questions among doctors.

“There is stigma and discrimination,” Dr. Klitzman said. “A few of these doctors said when word got out that they were diagnosed with cancer, colleagues suddenly stopped referring patients to them, or asking them to be on research grants or on projects or to help write papers like they used to. People are concerned that they are going to be peripheralized because so much of their identity comes from being doctors, and ‘doctor equals health.’ If you’re sick, it’s very difficult.”

David Goldman, MD, Goldman Eye, Palm Beach Gardens, Florida, said he doesn’t think there is stigma in doctors becoming patients per se, but the fear of how it will affect them professionally is real.

“I know several MDs who have hidden their medical conditions from others for fear it may affect how patients and/or colleagues perceive them,” Dr. Goldman said.

Dr. Goldman went on to describe a situation at a major meeting where an ophthalmologist was having a fundus photo taken as part of a demonstration. When the image appeared on the big screen, his friend said, “I didn’t realize you’ve had a retinal tear.” The doctor became visibly embarrassed, Dr. Goldman said.

Perhaps the issue with doctors getting sick is that it subconsciously suggests their identity has changed from that of a doctor to that of a patient,” Dr. Klitzman said.

“It’s often hard for these doctors to switch roles like that because they’re used to being in charge and having the answers,” he added.

“When you’re the patient, you don’t have the answers; you can’t always cure it.”

### Self-doctoring

Another issue that might present when a doctor gets sick is self-medicating.

“There’s an old saying that any lawyer who represents himself has a fool for a client,” Dr. Klitzman said.

“It’s often hard for these doctors to switch roles like that because they’re used to being in charge and having the answers,” he added.

“When you’re the patient, you don’t have the answers; you can’t always cure it.”

A review of 27 studies published from 1990 to 2009 found that in 76% of those studies, more than 50% (a range of 12–99%) of physicians and medical students had self-treated.  

“Deeper analysis of studies revealed

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**Tips to keep in mind**

- Have a primary care physician
- Avoid self-doctoring and self-medicating
- Learn from your own patient experiences and apply to your practice
- Take time to eat right, exercise, and spend time with family and friends
- Don’t forget: You’re only human and that’s OK
that physicians believed it was appropriate to self-treat both acute and chronic conditions and that informal care paths were common within the medical profession,” Montgomery et al. wrote.

**Lessons**
While becoming a patient is never easy, whether you’re in the medical profession or not, there are some lessons that can be learned by doctors and applied to their medical practice.

“A lot of these doctors learn things that help them with their patients,” Dr. Klitzman said.

One, for instance, is how to handle spiritual topics if the patient brings them up.

“One doctor told me, ‘Patients used to say, Doc, would you pray for me? I’d say, yeah, yeah, but pooh-pooh it. Then I became a patient, and I suddenly realized how important questions about meaning and end of life and spiritual issues are.’

In medical school we teach little, if anything about spirituality and religion ... but I think these doctors realized what it was to be a patient, which was to wrestle not only with the medical issues of ‘Will drug X cure my disease?’ but also ‘What does this all mean? Am I going to die? Is this the end of my life, if it’s a serious disease?’

Doctors became more aware of those more human aspects of illness.”

Doctors who experience being a patient also become more aware of communication issues and how the patient experiences could be improved.

“One of these doctors, who was a surgeon himself, said the night before undergoing surgery himself, as a patient, his surgeon said to him, there is a 5% chance you may die tomorrow in the operating room. ‘It was only later that I realized that my surgeon could have said to me instead, there’s a 95% chance that things could go OK.’ This surgeon turned to me and said, ‘I’ve been a surgeon for 40 years, and I never realized that those two bits of information that are statistically the same are completely different from a patient’s point of view.’”

After spending 45 minutes in a waiting room, a doctor might think differently about the patients he or she had previously kept waiting. Experiencing unremitting nausea or fatigue, once perhaps brushed off as annoying but insignificant symptoms before, might take on new meaning after a doctor battles those same symptoms.

What about practicing what one preaches? It’s easy to tell a patient to eat right and exercise regularly; it’s another to do it yourself.

“One of these docs who is an endocrinologist said he tells patients every day to eat a diabetic diet—low salt, low calorie. So he decided to try a diabetic diet—he only made it to lunch,” Dr. Klitzman said. “Some of them realize that what we preach is hard to follow. Some doctors use their experiences to try to preach it better or communicate it better with their patients.”

**Taking charge**
Research suggests that doctors who practice healthy behaviors are likely to influence positive behaviors in their own patients.

Dr. Goldman said physicians should make sure they are dedicating time for exercise and for their families, as well as trying to eat healthy, as good first steps at preventative physical and mental health measures.

Dr. Klitzman said making sure one has a primary care physician is a good start. He said that while there will always be an element of self-doctoring among physicians, self-medicating should be avoided.

“Try to learn from the experience and realize that, unfortunately, when it comes to ourselves, we’re not objective. Self-doctoring and self-medicating can get in the way of good care, and we need to be very wary of that.”

Finally, Dr. Klitzman said his fellow MDs need to realize that “we’re only human.”

“We have training and can help many patients, but we are fallible and can easily run into the same obstacles that our patients face. We can use that to be better doctors and take better care of our patients,” he said. OB

**References**

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7 tips for presenting refractive cataract surgery to patients

by Liz Hillman, Staff Writer

How to talk about out-of-pocket refractive options for cataract surgery to increase conversions
Cataract surgery has more options than ever: manual capsulorhexis vs. femto laser-created; manual chopping vs. femto fragmentation; limbal relaxing incisions vs. toric IOL; monofocal IOLs vs. multifocal IOLs; intraoperative aberrometry, and more. When presented with all of these options, patients can get what Shamik Bafna, MD, Cleveland Eye Clinic, Cleveland, calls “analysis paralysis.”

“Initially, when we started this process, we tried to give too much information at the very beginning. Patients were overloaded and said, ‘Let’s just do what insurance covers—I don’t want to deal with anything else,’” Dr. Bafna said.

For patients who might have valued spectacle independence after cataract surgery, this is an opportunity lost, both for them and for the physician who could have performed a potentially more satisfying surgery.

But counseling a patient on cataract surgery that could have a superior refractive outcome without feeling like you’re a salesman can be nuanced.

“Most people did not go into ophthalmology to be involved in retail-type sales, so this is something that makes doctors uncomfortable,” said Richard Tipperman, MD, Wills Eye Hospital, Philadelphia.

Both doctors offered pearls for counseling patients on cataract surgery options that help them make the best decision for their refractive goals, which might mean sticking with monovision and glasses, or it might mean femtosecond laser-assisted cataract surgery with a multifocal IOL.

1. Be outcome oriented

Understanding a patient’s visual goals from the start—a reasonable target outcome—can eliminate a lot of needless talk about technologies that might not be of interest or applicable to them.

Instead of speaking with patients about every cataract surgery option under the sun, Dr. Bafna said his practice started to lump various technologies together into broad categories from which patients can choose.

“From a consumer standpoint, I want to achieve a certain level of vision. When I choose a provider … I trust that provider to make the right choices and try to determine what I need in order to get that particular type of outcome,” Dr. Bafna said.

As such, he spends more time speaking with patients about their hobbies, their profession, and what they hope to achieve with their vision after cataract surgery.

2. Consider a fixed price point

In addition to bundling technologies into broad categories based on desired outcomes, Dr. Bafna said he keeps those bundles at a fixed price point as well. This gives the physician more freedom to change technologies, if necessary, to achieve that outcome without an awkward financial discussion.

“The perfect example is a patient with 1 D of astigmatism,” Dr. Bafna said. “In the past, I used to be in a difficult situation where, for example, I told the patient [I would put in] a toric lens. If I ended up not using a toric lens, [I would have to] go back to the patient and refund money.

“Or worse, let’s say I’m in the OR and I thought I was going to do an LRI and I determine that the best thing is a toric lens. I’m thinking ‘Do I put in a toric lens and after the fact say I need another $900 to cover a toric lens?’ It’s an awkward situation.

“I’ve felt at the time of surgery that a toric IOL would be the right thing, but because the patient had chosen an LRI, I went with the LRI and felt like I compromised,” he said, explaining that bundling technologies in packages with fixed prices helps avoid those situations.

Doing this, he said, has raised the cost of these refractive cataract surgery options by about $1,000.

“I analyzed in what percent of my cases I was using toric lenses, in what percent of my cases I was using LRIs, and then tried to find a price point that was in the middle of those two,” he said. “If I put in a toric lens, maybe I lose a little bit, but I make up enough from my LRIs that I don’t think about it,” Dr. Bafna said.

3. Choose the right word

Standard, routine, conventional vs. basic. Premium vs. advanced technology. Word choice can make all the difference, according to Dr. Tipperman.

“The second you say standard, people assume that’s the operation everyone will have because everyone wants what everyone else gets,” he said. “But if it’s a basic operation, they understand it a bit differently. … It’s not pejorative; it describes to the patient what it is. You get what you pay for and not much more.”

Premium, on the other end of the spectrum, implies luxury, Dr. Tipperman said.

“People are not willing to make a luxury purchase, but they are willing to make a purchase for technology that is better,” he said. “That’s why I think a lot of how you describe it to patients is helping them understand what is the value proposition of what they’re getting out of surgery. Sometimes, if they miss the value proposition, they don’t realize that it is something that is at least worth considering.”

Instead of premium, Dr. Tipperman prefers calling options that allow for refractive outcomes advanced technologies. As for describing these specific technologies, Dr. Tipperman said he thinks patients understand astigmatism-correcting IOLs more than the term toric, for example. Instead of monofocal or multifocal IOLs, he uses the terms fixed-focus lens and lenses with more range of vision or focus, respectively.

In a presentation at the 2016 Combined Ophthalmic Symposium in Cleveland, Dr. Tipperman said he thinks patients understand astigmatism-correcting IOLs more than the term toric, for example. Instead of monofocal or multifocal IOLs, he uses the terms fixed-focus lens and lenses with more range of vision or focus, respectively.

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Austin, Texas, Dr. Bafna said he tells his patients that the femtosecond laser can soften the lens like a cookie that has been dunked in milk, giving them the visual picture of it making it easier for the pieces to crumble.

Dr. Bafna describes cataract surgery as a whole as an opportunity.

“When someone presents for cataract surgery, there are different ways you can talk about it. You can talk about it as a pathology … but I like to present it as an opportunity to the patient. You have an opportunity to make a decision that will help you gain more freedom in various activities,” he said.

Dr. Tipperman said it’s also important that all staff members speak the same language—from the physician to the technician to the scheduler.

4. Put the cost in context
Dr. Tipperman gave the example of an $180 Prada T-shirt. While expensive for a T-shirt, when it’s on display next to an $18,000 purse, it suddenly seems less expensive. This is a framing effect, Dr. Tipperman said.

“The idea of framing effects for ophthalmology and advanced technology lenses is to [help patients understand when they] ask how much it costs. It’s less than half of what a hearing aid costs. It’s less than what a dental implant would cost. … It’s about what cable TV will cost for 6 months, but then the cable is free for the rest of your life.

“You’re going to have cataract surgery on one of your most precious sensory organs … and you obviously want to get the best vision you can out of surgery; do you think it would be worth spending less than a 6-month cable bill to get good vision for the rest of your life? Suddenly, it doesn’t seem like a crazy purchase anymore,” Dr. Tipperman said.

5. Bring in family
Just as putting the out-of-pocket costs in context gives patients perspective, so can the people closest to them. Both Dr. Tipperman and Dr. Bafna said they’ve noticed older patients being more reluctant to spend money on themselves.

“Oftentimes if you have the patient alone, it becomes more of a monetary decision. If a significant other or spouse or child is there, they’ll be more likely to say this is the right thing for the patient,” Dr. Bafna said.

“That’s the family being the person’s advocate and helping them make a better decision,” Dr. Tipperman said.

6. Spread out education
Even though he avoids going into all the different technologies and details of refractive cataract surgery, the information patients need to make an informed decision can still be a lot, Dr. Bafna said. This is why he spreads out this education.

“If you try to give all this education in one sitting, it’s too much for the patient to absorb. You’ll find that they don’t have time to appreciate it,” he said.

In his practice, patient education starts with an informative packet sent to their home. They’ll then learn more when they meet for a consultation and more still when they sign up for surgery. Dr. Bafna said he might even have a counselor reach out to patients ahead of surgery to see if they have further questions.

“By increasing the education process, that increases the number of conversions because it gives patients the chance to digest the information, figure out what they want, ask questions, and go from there,” he said.

7. Give them time
Dr. Tipperman said he tells patients to take time to make a decision after their initial consultation.

“This is a decision that will impact how you see for the rest of your life,” he tells his patients, as he advises them to think about it.

This, he said, helps the patient realize the magnitude of the procedure and this decision.

“They realize it’s a big decision because they’re going to have cataract surgery once in their life. This is the one time they can get the most functional vision or the best vision,” he said.

Takeaway
Overall, Dr. Bafna said making changes to bundle fixed-price services based on outcomes as well as using selective language and involving the family more has improved his conversion rate.

“Prior to making these changes, we were around 15% to 17% for upgrades … now we’re closer to 35% to 40%. We’ve doubled,” he said.

Dr. Bafna noted, however, that this increase isn’t 100% due to these changes.

“It’s partly because technology is continuing to improve, and I think patients may be more aware of what’s going on,” he said, adding that he finds it encouraging that despite increasing his prices, overall conversions still went up. “That’s why I felt like the changes did have an effect.”

“Eight years ago it was pretty common for people to say, ‘Doc, are you sure? My insurance probably covers it—I have good insurance.’ You never hear that from people anymore,” Dr. Tipperman said.

“Instead you hear, ‘My neighbor had it. I know I have to pay for it. I’m OK with that.’ I think people have become better educated about what are out-of-pocket expenses and what are covered expenses.” OB

Editors’ note: Dr. Bafna has no financial interests related to his comments. Dr. Tipperman has financial interests with Alcon (Fort Worth, Texas) and Diopsys Inc. (Pine Brook, New Jersey).

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Long-term indicators can provide **buy** or **sell** signals

by Roger Balser

Since the late 1990s, we’ve been using a “point-and-figure” charting method at Balser Wealth Management, with good success. These charts are great for looking at mutual funds, stocks, bonds, and even interest rates. Using these charts, one can clearly see when stocks are moving in a positive direction or a negative direction. We call these trends, and they’re simple to read and understand if you’re an inexperienced investor because all you have to do is look at the pictures to determine what’s going on with any particular issue.

What’s great about point-and-figure charts is they can give us the direction of the markets as well. There are several charts that I regularly monitor just to gauge the temperature of the market. I’ve divided these charts into long-term, intermediate-term, and short-term indicators.

I’d like to take a look at the long-term indicators because they provide a clear backdrop of what is going on in the markets.

What’s interesting is that when you look back at the various signals that are given on these charts, you can associate them with some pretty big turns in the markets. Here are three long-term indicators that I’ve come across that provide great signals.

The first is the “bullish percent for all mutual funds” (Figure 1). It seems crazy to get a long-term indicator from mutual funds, but this indicator gives us a long-view picture of money in motion.

The bullish percent is the percent of charts in the universe based on buy signals. The chart displayed here is the bullish percent for all equity mutual funds. The number on the left is the percentage of equity mutual funds on point-and-figure buy signals.

![Figure 1: Bullish percent for all mutual funds on a 2% scale](image1)

![Figure 2: Percent of mutual funds that are in a positive trend on a 2% scale](image2)
For reference, a column of X’s means the issue is moving up, which is good. A column of O’s means it’s moving down, and that’s not so good.

You also need to know the buy signal or sell signal. A buy signal is where a column of X’s exceeds a previous column of X’s. A sell signal is where a column of O’s exceeds a previous column of O’s. It’s not necessarily as important to know the patterns as it is to be able to identify the column and signal.

This chart has an uncanny ability to foreshadow big losses in the markets. In July 2008, this indicator reversed into a lower column of O’s from a higher top, with two sell signals. In August 2011, a reversal from a higher top occurred when the U.S. was going through a debt crisis. Then in August 2015, another column change was followed by two sell signals. We currently see this indicator moving positive, and that’s good.

This is what makes the “bullish percent for all mutual funds” a pretty good long-term indicator.

The second long-term indicator I monitor is the “percent of mutual funds that are in a positive trend” (Figure 2). What do I mean by a positive trend?

Any chart that is trading over and above its support line is in a positive trend. It can go up and it can go down, but as long as it stays above support it signals a positive trend. This chart doesn’t speak often, but when it does you’d better be listening.

It’s important to remember that when you’re looking at long-term charts, you need to be aware of your field position and whether you’re on offense or defense. These charts help you do just that.

When they’re at washed-out levels and begin to reverse up, then you have the wind at your back and the odds of making money are pretty good. Likewise, when they reverse down from lofty levels, you want to be careful with your investments.

It’s interesting to note that this chart produced a sell signal three times in 2008. One in January, another in July, then a third in September of that same year. So this indicator gave us a pretty good overview of what was happening in 2008. It also reversed to O’s in August 2011 (as our other indicator did when the U.S. was struggling with its debt nonsense). Currently we’re positive, but on a sell signal.

Our final long-term indicator is the “measure of cash versus equities” (Figure 3). For cash we use the 13-week treasury bill rate compared to the S&P 500. Like the two charts above, it’s important to determine whether you’re on offense or defense and your field position. When this chart reversed, it occurred (again) at major turns in the markets. In July 2008, it turned, and in March 2009, it turned again. In November 2011, it showed a second buy signal, then in March 2012, a third buy signal.

These long-term charts clearly help me to paint a picture of whether we are on offense and in a wealth-accumulation mode, or on defense and in a wealth-preservation mode. 

Figure 3: Measure of cash versus equities on a 3.25% scale

Source (all): Roger Balser
The “opportunity” in dry eye is the chance to improve patient outcomes

“In fairness to the patient, our practices can and should be performing work-ups to understand the nature of the problem. Then, if we are not going to treat these patients, we owe it to them to refer out to someone who will.”
While a practice can garner tremendous revenue from proactively identifying and treating dry eye disease, the financial aspects are secondary to the interest of providing good medical care that patients deserve. There are myriad value-add services that an eyecare practice can offer to better serve patients, but in my mind, managing dry eye is a core capability that every eyecare practice should have. In a lot of ways, ignoring the dry eye patient is akin to ignoring a patient with elevated intraocular pressure and signs of glaucomatous change.

With the upcoming changes in reimbursement, we are all faced with being measured in ways we still don’t understand. Taking care of patients is what we do and we should all do our best to meet patient needs. So when I hear people ask whether eyecare practices should add dry eye services, my response is, “Why haven’t they already?” When it comes to dry eye, whether or not to treat dry eye is a binary calculus, whereas the real question is how extensively they want to treat the problem. Similar to glaucoma, there is no question whether patients with a history of or who are at risk for glaucomatous optic neuropathy should be evaluated; the more appropriate question with respect to practice philosophy is whether one wants to offer medical management, perform laser, or have the capacity to provide surgical intervention. One either has means to vertically elevate the care of glaucoma or else has a trigger for when to refer to an external specialist provider.

The same scenario should be in place for individuals with dry eye disease. In our practice, an estimated 80% of patients present with some signs or symptoms that can be indicative of dry eye disease. Some of these patients are asymptomatic just as the glaucoma patient can be and are relying on our profession to diagnose and “protect” their ocular health. In fairness to the patient, our practices can and should be performing work-ups to understand the nature of the problem. Then, if we are not going to treat these patients, we owe it to them to refer out to someone who will.

An educated staff is the best way to educate patients

When dry eye is considered a core service and treated as a primary disease, it is already a part of the practice’s revenue stream. Where many practices get tripped up is in the fact that many therapies and diagnostics are not covered by insurance. Part of the issue many practices face is a failure to educate patients about the benefits derived from treatments and diagnostics. These benefits should be presented regardless of the financial status of the procedure, product, or therapy.

For instance, Bowden Eye in Florida has found Prokera (Bio-Tissue, Doral, Florida) to be beneficial in our severe dry eye patient base. This is an easy product to educate patients about, and they find it fascinating. By precerting the coverage and educating the patient about the benefits of use, the patient gets to decide based on the physician’s recommendations.

Regardless of one’s carrier recommendations, a practice should develop a standard of care that is best for the individual practice and the patient and allow the patient to pay when the insurance will not be following proper reimbursement steps. Education truly is key.

As with many things in eyecare, properly educating patients about treatment benefits is a direct result of staff education. In our center, we place a large emphasis on ongoing and continual training, which we provide in various formats. Our belief is that it is easier to add new components to our core services if we pay attention to the infrastructure on an ongoing basis; we would be working against our own best interest if we reinvented the wheel every time we wanted to add a new diagnostic or when a new drug came out.

In addition to quarterly full-day training seminars involving every member of the staff from each location, we also have monthly meetings among team leaders to review how well we are doing and to identify gaps.

Dry eye in practice

Every patient that comes into one of our clinics is administered the SPEED questionnaire by one of our technicians, each one of whom has been empowered to initiate further testing based on results. This may be the single most important thing we can do for dry eye patients; it is a practice that is low cost with a high rate of return. Any patient with a score greater than zero who has a chief complaint that includes a dry eye symptom or who was previously treated for dry eye will be identified for further evaluation. We have a number of advanced diagnostics that help determine what factors are playing a role, including tear osmolarity testing (TearLab, San Diego), the InfllammaDry point-of-care test (Rapid Pathogen Screening, Sarasota, Florida), and LipiView (TearScience, Morrisville, North Carolina). We recently added scatter testing using the HD Analyzer (Visiometrics, Barcelona, Spain).

We think these diagnostics are important for many reasons. First of all, recent evidence suggests that dry eye is multifactorial and that understanding if aqueous deficiency or meibomian gland disease is involved is only part of the story. We have learned that blepharitis and a number of other masquerade syndromes may either mask signs and symptoms of dry eye or they may coexist and serve as triggers to exacerbate and worsen a patient’s condition. If we gather baseline data, we will

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have a truer sense of the response to treatment over time. For example, as our doctors treat the inflammatory component, patients should see reduced inflammation on repeat InflammaDry testing and osmolarity should normalize. This fact points to the value of the objective data gained from these tools as valuable for patients’ education.

Advanced diagnostics also help our doctors to direct treatment to the underlying cause. We have learned that inflammation is an important factor in causing and exacerbating dry eye disease. Therefore, treatments like Restasis (cyclosporine, Allergan, Dublin) can be important for treating patients who present with signs of dry eye but will only be effective if dry eye is in fact present, thus highlighting the need to rule out masquerade and look-alike syndromes.

It may seem obvious, but it is amazing how often the need for a positive diagnosis is overlooked in the midst of busy clinic operations. At the same time, advanced diagnostics might alert our physicians to the fact that other elements beyond the inflammation require treatment.

**Elevating the standard of care**

If constant training and education and an emphasis on advanced diagnostics serve as the backbone to our dry eye capabilities, the addition of educational adjuncts help complement our goal of providing patients high quality results in an efficient and effective manner that benefits all sides.

One example is that we rely on specially trained counselors to help educate patients about their various options. It is something we learned the value of from the premium IOL market, where consultations with a highly trained expert help start the patient off on the right foot; our physicians’ valuable time is reserved for a meaningful encounter with the patient. But the use of dry eye counselors is about so much more than building greater efficiency and more voluminous patient traffic. Thanks to recent breakthroughs in the science and the availability of so much technology, the dry eye space has become much more complex. It would be easy to overwhelm patients with information overload, and expecting our medical staff to provide all the education in a condensed patient encounter might be equally stressful to them.

**Cash pay services: Worth the investment?**

Our practice philosophy when it comes to dry eye disease is that every patient is worthy of evaluation. We constantly see patients with dry eye who are suffering considerably from their symptoms. Yet there are good diagnostics that can help the provider understand the problem, and there are equally good and effective therapeutic strategies to treat the underlying problem.

One aspect of dry eye that I see many practices struggle with is that there may be discomfort in asking patients to pay out of pocket for certain services. Our response is that we are never selling services to patients; we are providing them opportunities to select additional services that will help us understand the nature of their problem and how to treat it. This is much more than a semantic shift because the reasonable person who took the time to come into the office for an appointment is interested in how to solve their problems.

This last principle sums up our approach to dry eye disease in our practice: We start by standardizing a high standard of care because medical necessity should trump all other concerns. We engage patients in meaningful conversation to convey benefits, but we do so under the premise of presenting options and providing needed education. Sometimes that conversation is the final step in working with a patient with dry eye disease, but often we will make recommendations for how we think we can make the patient feel better. Depending on the patient’s financial comfort with additional services, we will suggest them as needed and as appropriate.

The dry eye market has gravitated in a similar direction to the premium cataract surgery market, where the practice builds on core capabilities by adding services that meet the interest level in providing quality care. Some patients will be comfortable paying extra and some will not. But the major difference is that unlike a premium IOL offering, the patient with dry eye disease is dealing with a disease process and will continue to do so if the disease is not properly diagnosed and treated. On a larger level, we are building a relationship with patients who are having trouble with their vision to let them know that we are able to help and intervene. Our core services will provide a fully appropriate recommendation for fixing their problem, and because we are serious about the dry eye problem, we have the capability to add additional services that may enhance the experience and the outcome.
Are you sure you’re covered?

by Liz Hillman, Staff Writer

Review the insurance policies you really need

The “I” word—insurance—can be a turn-off for many people. “What it means is, I’m spending money for something I can’t see and hold and may never use, but I’ve got to do it,” said Robert Meadows, executive vice president, Professional Risk Associates, Midlothian, Virginia.

Physicians are faced with a myriad of insurance options—some mandatory, some elective, and some that they might not even know about.

As a physician, you are probably familiar with the types of insurance that allow you to practice and run a business, but there are other policies worth considering as well.

Tariq Qamar, MD, medical director, Q Vision, Scottsdale, Arizona, started looking into his own insurance policies after being introduced on the ASCRS forum EyeConnect to a type of insurance he didn’t know about before. It was regulatory protection.

“It gave some scary scenarios of how that [coverage] might be needed,” Dr. Qamar said. “That inspired me to look into regulatory protection. As I was looking into that, I kept coming up with new types of insurance—cyber liability, PCI DSS [payment card industry data security standard], and things like that.”

The different types of policies and coverages are “overwhelming,” Dr. Qamar said.

Lesser known insurance offerings

While on EyeConnect, Dr. Qamar was surprised to learn about types of insurance policies that are increasingly considered important in this day and age.

One of them is regulatory protection, also called medical defense coverage. According to Mr. Meadows, this provides defense against claims of fraud and abuse, improper coding, or if a physician is summoned before a medical board or disciplinary committee.

Dr. Qamar said he is in the process of purchasing regulatory protection coverage as well as another increasingly important type of insurance he didn’t have before: cyber liability coverage.

“That’s very important coverage right now,” Mr. Meadows said. “You might read about a hospital being hacked and so forth, but it’s not unusual for medical practices to be hacked also.

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“On the black market people will pay a lot more for medical records than they will for a social security number ... or a credit card number,” he continued. “That’s because medical records have a lot of personal information about people, including name, address, social security, health care information, and so forth.”

For physicians who run solo or small practices and think they won’t be the target of a cybercrime, Mr. Meadows said it’s more common than you might think.

“The vast majority of these cyber information-type claims are from disgruntled employees who leave the practice and take information with them and the next thing you know, it’s out there on the internet,” he said. “We see claims like that every day. It can be a real problem.”

Even if the practice is small, Mr. Meadows pointed out that it still has a lot of patients and could be a target.

Back to basics
Malpractice insurance is standard, if not required, to practice medicine, depending on the state, practice, or hospital setting. However, it is not unheard of for doctors to “go bare,” assuming out-of-pocket financial responsibility for claims that might be brought against them. Those going without malpractice coverage likely did so because of high premiums, but Mr. Meadows said this cost has gone down over the last 5 to 10 years.

The reason? The incidence of new claims reported has not been increasing dramatically during that time, he said, and more carriers have decided to include medical malpractice offerings, creating more competition and driving down the price. This has been a positive trend for physicians, Mr. Meadows said.

There are other types of coverage that don’t relate to the professional liability that practices should have. If you’re leasing or renting a space, you’ll need a business owner’s policy, which covers incidents like slips and falls and general liability situations.

If your practice has high-tech equipment, you’ll want to make sure you have that specifically insured up to its value.

If you employ others, you’ll need workers’ compensation coverage and employee liability coverage for claims brought by an employee against the business.

Where are physicians getting information about the types of insurance needed and available to them? Dr. Qamar said most pick it up gradually and that, Mr. Meadows said, can be dangerous.

“If you’re learning on the job, what if you’re [practicing] 6 months or a year and haven’t learned yet about cyber liability exposure or medical defense exposure? You think you’ve got yourself covered and all of the sudden—bam. Because you weren’t aware of that and you get a claim, you don’t have coverage, and you’re in a place where you don’t want to be,” Mr. Meadows said.

A class or seminar in medical school or residency before a doctor gets out in the “real world” could be helpful, but Mr. Meadows said insurance agents are a good resource as well.

“At a minimum of once per year when your insurance renews, your agent should do a full review with you. They should talk with you about any changes that may have occurred during the year in the practice. They should talk with you about what’s going on in the marketplace. ... They should do a review of your insurance program to be sure that you’re aware of what you have, you’re aware of what’s out there as far as new risks and new policies, and also the fact that you’re getting the best policy at the most competitive price for your situation and practice,” Mr. Meadows said.

Being proactive with one’s agent is important as well. Bringing on a new doctor, acquiring new equipment, offering a new, potentially riskier procedure, for example, merit a conversation with your insurance agent.

“All of those are times when you want to talk with your insurance agent, and they can let you know whether or not that’s something that needs to be added to your policy or is something that’s already covered,” Mr. Meadows said.

“Physicians want to practice medicine. What we want to do, as all agents do, is take care of the insurance part so they have more time to do that, but it’s the physician who has to say, ‘I need to take a look at this; I need to be educated on this’,” Mr. Meadows continued. “They need to realize that the last thing they want is to not have the requisite coverage that they need because then they’re self-insuring, and any issues they have are going to come out of their pocket.”

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Types of insurance options
• Medical malpractice
• Business liability
• Umbrella liability
• Property
• Workers’ compensation
• Disability
• Office overhead
• Regulatory protection (medical defense)
• Cyber liability
• PCI DSS
• Life insurance
• Long-term care insurance
Portable device simulates different IOLs before surgery

by Liz Hillman, Staff Writer

Could help to determine patient preference, tolerance before implantation

Ophtalmologists can take measurements, make observations, and provide their best recommendations to a patient about different IOLs that could be used at the time of cataract surgery, but all patients are different. It can be difficult to predict how they’ll react to a multifocal IOL, if they will tolerate monovision, or how they’ll adapt to side effects like halo. It can also be difficult to describe to them the level of spectacle independence they could achieve with a refractive IOL compared to a monofocal option.

If an IOL is implanted and the patient’s expectations are not met, an IOL exchange or touch-up procedure might be required, but what if it was possible to test a variety of IOLs on the patient before he or she was implanted?

The Institute of Optics in Madrid has created SimVis, a portable simultaneous vision simulator that allows patients to experience the effect an IOL would have before it is implanted.

“Clinicians often fail at offering a multifocal solution to a patient if they subjectively believe that patient may not be satisfied postoperatively, or if they find unsatisfied patients following multifocal IOL implantations,” wrote the authors of an article published in the journal Optica.1 “Contact lens specialists often rely on a trial-and-error approach, trying multiple contact lens designs until the optimal solution is identified. We have presented a novel portable through-focus simultaneous vision simulator that allows experiencing the real world through realistic optical simulations of multifocal corrections. The system holds promise as a tool to help in selecting the optimal treatment for the patient.”

While there are other visual simulation devices on the market, the SimVis prototype uses what Susana Marcos, PhD, director of the institute’s Visual Optics and Biophotonics Lab, called “temporal multiplexing.”

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“Most visual simulators are based on adaptive optics,” she said, explaining the technique that can be used to mimic corrections.

She said these types of simulators are large and bulky compared to SimVis, which in its latest iteration is wearable and allows patients to see the world through the instrument, providing them with the experience of seeing the correction at varying distances with different IOL options.

“Multifocality is simulated by rapidly varying the optical states of the lens and controlling the state of the lens (focus position) and the amount of time the lens remains in any given state (energy dedicated to a particular focus). This variation is faster than the visual fusion frequency, so the temporal multiplexing produces retinal images that are perceptually static,” the study authors wrote.

The research published in Optica described nine subjects between 20 and 62 years old who tested the device, which simulated three monofocal, two bifocal, and two trifocal lenses. The researchers measured visual acuity and perceived visual quality for near, intermediate, and distance vision, comparing the different types of correction. Overall, the researchers found “large inter-subject variability in the preferences across lens designs, with each subject revealing a different preference pattern,” which one might expect.

The study participants did not have cataracts, but Dr. Marcos said they have tested the device in cataract patients and found it functioned well despite a clouded lens.

“The ranking of the different designs and their preference was perfectly achievable,” she said.

Dr. Marcos called the patients’ preferences to the different corrections subjective, but said they are “based on a series of well-established comparisons and a statistical response for what lens is better.” The instrument can also simulate side effects like halo, allowing patients to experience what that will be like before selecting a multifocal IOL.

The device is programmable for the specific corrections offered by IOLs currently on the market, but Dr. Marcos said that it could be used in the development process for new IOLs as well.

“From a commercial perspective, the primary customers would be the ophthalmologists who want to have the patients try the lenses before they’re implanted in their eyes. The instrument can also be used by intraocular lens or contact lens manufacturers that can try different designs before they’re manufactured or commercialized. In our lab we’re working with some intraocular lens companies before an intraocular lens is launched,” she said.

Because multiple lenses can be tested on the same subject—the same brain—it allows researchers and manufacturers to better compare designs.

The SimVis device evolved from a handheld, monocular piece to one that is even smaller, binocular, and can be worn by the patient. This allows the patient to walk around with it and experience it in, for example, outdoor environments; in addition, the technician can program it to test patient preference with monovision or where one eye gets a multifocal IOL and the other gets a monofocal IOL, for example.

Dr. Marcos thinks that the latest generation of the prototype is close to being ready for the clinician.

“The next research step is to bring it to the ophthalmologists’ and optometrists’ offices and have it used and prove the commercial value of the instrument,” she said. “[We want to prove] that it is increasing patient satisfaction when the instrument is used, and this increases the success of the multifocal intraocular or contact lens prescription.”  

Reference

Editors’ note: Dr. Marcos is co-inventor of three patents on SimVis, and cofounder of 2Eyes Vision, a spinoff company that commercializes SimVis.

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For more information on the SimVis headset, go to www.2eyesvision.com.  

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